EDMUND G. BROWN JR., Attorney General
of the State of California
FRANK H. PACOE
Supervising Deputy Attorney General
LESLIE E. BRAST, State Bar No. 203296
Deputy Attorney General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5548
Facsimile: (415) 703-5480

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JANE DONG REN** 6029 Monterey Ave. Richmond, CA 94805 Registered Nurse License No. 517162 Respondent.	Case No. 2008-2660 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant,) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about October 24, 1995, the Board of Registered Nursing (Board) issued Registered Nurse License Number 517162 to Jane Dong Ren (Respondent). The license was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2009, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTORY PROVISIONS

6. Code section 2761 states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical

sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COST RECOVERY

10. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

///

///

FACTUAL BACKGROUND

11. On or about July 7, 2004, while working as a registered nurse in the General Acute Care Unit (GACU) at Sonoma Developmental Center (SDC)[1] in Eldrige, California, Respondent administered the wrong medication to a 23-year-old patient by improper means, failed to properly document her medication errors, and failed to recognize and appropriately respond to the signs and symptoms of the patient's illness.

a. The patient, Philip Q.,[2] was a life-long resident at SDC with a diagnosis including cerebral palsy, seizure disorder and episodic pneumonia secondary to severe Dysphagia (swallowing) Syndrome. During the 18 months prior to his death, he had developed an increasing number of pneumonias. On or about July 5, 2004, he developed a fever with respiratory distress and dangerously abnormal vital signs; he was thereafter transferred to the GACU to receive a higher level of nursing and medical care. Respondent did not recognize the gross abnormality of the patient's vital signs, and did not properly assess, track and document his status.

b. At approximately 8:00 PM on or about July 7, 2004, Philip Q. was scheduled to receive his standing 60 mg dose of phenobarbital.[3] Instead, Respondent administered 60 mg of morphine sulfate.[4] He had a brief seizure approximately two hours after missing his phenobarbital.

///

---

1. SDC is a residential facility, governed by the California Department of Developmental Services, for people with developmental disabilities.

2. On July 9, 2004, Philip Q. was transferred to Sonoma Valley Hospital where, on July 13, 2004, he died of respiratory failure with bilateral pneumonia. His full name is withheld to protect his and his family's privacy; it will be disclosed in discovery, upon request.

3. Phenobarbital is an anticonvulsant, commonly used in the management of seizure disorders.

4. Morphine sulfate is a powerful analgesic used for preoperative sedation, as a supplement to anesthesia, or to relieve severe pain. Respiratory depression is the chief hazard of all morphine preparations. Respiratory depression occurs most frequently in elderly and debilitated patients, and those already suffering from respiratory ailments.

c. The morphine sulfate was an extended-release preparation. Extended-release tablets should be administered whole and intact and *not* broken or crushed.[5] Respondent crushed the morphine sulfate extended-release tablets and administered them through Philip Q.'s gastrostomy tube.

d. Respondent's medication errors were not recognized until a routine medication count was performed during the evening shift change, approximately three hours later. Upon learning of her errors, Respondent did not correct the medical record, as required by facility procedures, to reflect that Philip Q. received morphine sulfate extended-release tablets, crushed through his gastrostomy tube, rather than his regular phenobarbitol dose.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence: Administration of Wrong Medication)

12. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), for gross negligence in that she administered the wrong medication to a patient, as described in paragraph 11, above.

SECOND CAUSE FOR DISCIPLINE

(Incompetence: Improper Administration of Medication)

13. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), for incompetence in that she crushed and administered medication that should only have been administered intact and unbroken, as described in paragraph 11, above.

THIRD CAUSE FOR DISCIPLINE

(Incompetence: Failure to Recognize the Signs and Symptoms of Illness)

14. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), for incompetence in that she failed to recognize that the patient's vital signs were grossly abnormal and failed to respond accordingly, as described in paragraph 11, above.

///

---

5. Intake of broken or crushed morphine sulfate extended-release tablets may result in too rapid a release of the drug and absorption of a potentially toxic dose of morphine sulfate.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Document Medication Administration)

15. Respondent is subject to disciplinary action under section 2761, subdivision (a), for unprofessional conduct in that she failed to follow the facility's medication administration documentation procedures, as described in paragraph 11, above.

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

16. Respondent is subject to disciplinary action under section 2761, subdivision (a), for unprofessional conduct in that she administered the wrong medication to a patient, crushed medication that should have been administered whole, failed to accurately document her medication administration, and failed to recognize and respond to the signs and symptoms of the patient's illness as described in paragraph 11, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 517162, issued to Jane Dong Ren;

2. Ordering Jane Dong Ren to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/18/08

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SF2007200802
40226135.wpd